VOL. 14, NO. 5 JAN.-FEB., 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physical examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
Associate Director

NORMAN DESROSIERS, M.D.
Medical Director

GEORGE H. ADAMS
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UNDER THE AUTHORITY OF THE ACT OF AUGUST 24, 1912

LATEST ON OVER-DRINKING

Leading Authority Answers the Questions Social Drinkers Ask

From a recognized authority on alcoholism comes a guide for social drinkers—how much it is safe for a person to drink, when and how often, the danger signs of over-drinking.

Any harm in a drink or two before dinner? How about cocktails at lunchtime? Should parents worry about teen-age beer parties?

In answering these and other questions, Dr. Marvin A. Block reports the latest medical findings on drinking, and gives his own views on how a man can enjoy alcohol without running the risk of becoming a problem drinker.

Dr. Block was interviewed by staff members of "U. S. News & World Report."

Reprinted from the June 15, 1964 issue of U. S. News & World Report, published at Washington. Copyright© 1964, U. S. News & World Report, Inc.

Q Dr. Black, how would you describe a "social" drinker?

A The average social drinker—there are approximately 75 million of them in this country—uses alcohol as a beverage to give him relaxation and allow him to get away from the cares of the day temporarily.

Q After work?

A In the U. S., the highest concentration of alcohol in the blood of the population is between 4 and 9 p.m.—the so-called "cocktail hour." During the rest of the day there's very little, if any, alcohol in the blood of most of the U. S. population.

Q What about cocktails at lunchtime?

A Unfortunately the custom of drinking before lunch has become quite a common practice. And I consider it a dangerous one. Alcohol belongs to the anesthetic drugs. It is a sedative, a tranquilizer. Now, why, in the middle of the day, should one want to be sedated, or given a hypnotic or an anesthetic?

Actually, I think one loses one's efficiency for the afternoon when one drinks at lunch. The average businessman today thinks nothing of having one or two cocktails before lunch. In my opinion, that reduces his efficiency for the rest of the day.

Q Does it increase his risk of becoming an alcoholic?

A I think when a man begins to drink during the day for no social reason—and a business lunch is not a social affair, no matter what efforts are made to make it one—then, I feel, he is beginning to drink out of normal context. And that is an early sign of alcoholism that we look for.

Now, I don't want to say that everyone who takes a cocktail for lunch is necessarily an alcoholic, or even an early alcoholic. But I do feel that drinking at that time of day at a luncheon devoted to business can hardly qualify as social drinking.

Q What do you think about a drink or two at the end of the day?

A It is a type of relaxing, taking it easy, allowing oneself to get away from care for a temporary period. But it should be only for a reasonable length of time. If one extends this escape into an

entire evening of drinking, in order to get relaxation for the entire time, this is carrying it too far.

Q Does liquor have a place at parties?

A Drinking alcohol as an aperitif used to be a gracious ritual at one time. One had a so-called appetizer before dinner and then went in to dinner, and this did no harm.

But that seems to have gone by the board. Now cocktail parties stretch on and on. Drunkenness for some at the party may ensue. And I think that our tolerance for drunken behavior is what gives the tremendous impetus to alcoholism in our country.

Let me get something straight. I'm not against all drinking. I'm not even a teetotaler, for that matter. But I see more and more tolerance of drunken behavior at so-called nice parties. I see more and more drinking out of social context. And I see the social pressures for drinking rising—you are offered a drink wherever you go. And these are the elements that are dangerous.

Q Are there danger signs that even the social drinker should watch out for?

A There is no sharp line of demarcation between the heavy social drinker and the alcoholic. As a matter of fact, it's a rather hazy area where he slips from one into the other unknowingly. But when his attention is called to some of the signs which might be considered indicative of alcoholism, he resents it. And this, itself, is one of the early signs of early alcoholism—resenting being called an alcoholic or having one's attention called to drinking patterns.

Another sign the social drinker should watch out for is the feeling that he needs a drink at a certain time or to face certain situations—meeting people at a party, for example. There are other danger signs—particularly loss of control over the amount one takes, taking more than one plans to, changes in behavior.

Q Are there any safe limits to which a social drinker should confine himself?

A Well, when one says "safe," one can say that up to .05 per cent of alcohol in the blood—that is, two ounces of whisky or two bottles of beer—up to that point the individual can be considered "safe" as far as driving an automobile is concerned.

When he gets up to four ounces of whisky or four bottles of beer, it's questionable.

And one must remember the amount of time it takes to metabolize—burn up—these drinks. The percentage of alcohol in the blood rises as one drinks. If one dosen't wait until it is metabolized, the percentage will rise much higher. So, taking three drinks in rapid succession can make one drunk much faster than stretching it over a period of time.

Q Is there a safe schedule or safe limit for drinking?

A Well, the average 150-pound man can metabolize one ounce of whiskey or about a half ounce of alcohol per hour. Now, if the average healthy man were to drink at that rate, he would not get drunk, he would not pile up the alcohol in his system beyond the rate by which it can be metabolized.

However, most people don't wait that long between drinks, you see. The alcohol rises in concentration in the blood, it backs up and is in the blood to a greater extent than the liver can metabolize it, as a result of which he gets drunk.

Q But one ounce of liquor an hour would be safe—

A The individual who would take a one-ounce drink an hour wouldn't have too much trouble. But how many people will space their drinks that far apart? And the alcoholic, particularly, won't even think of it, and he will tell you so very frankly. He'll say, "If I can't drink to where I feel it, I don't even want to begin."

And I think that one must recognize one important fact: The alcoholic does not **want** to drink normally. He wants to drink abnormally, because that's the only way he feels what he wants to feel. And, of course, when he feels that way, then he's hooked.

This is different from the normal drinker. (To be continued, next issue)

Dr. Marvin A. Block, a practicing internist of Buffalo, N. Y., is vice president of the National Council on Alcoholism and served 10 years as chairman of the American Medical Association's committee on alcoholism.

Understanding and prevention of alcoholism must start with the social structure and attitudes of our people toward drinking as they are today, not as they were 75 years ago.

Part I

ALCOHOL Its Social and Educational Implications

By The Late Raymond G. McCarthy

This article is reprinted from the proceedings of a 1963 conference on "Alcohol Education—Whose Responsibility?" (published by the Michigan State Board of Alcoholism) which was conducted under the auspices of the National Institute of Mental Health. The other sponsors were the Michigan Departments of Mental Health, Public Instruction and Health, the Michigan Congress of Parents and Teachers and Michigan State University. The author, the late Raymond G. McCarthy, M.Ed., was executive director of the Rutgers Summer School of Alcohol Studies.

SOMEONE has said that when our society is unable to resolve a difficult situation, there is a tendency to give it status by designating it as a problem. This surrounds the problem area with a degree of uniqueness which implies that little can be done about it. Obviously this tends to relieve society of some of its responsibility.

Although the remark I have referred to may have been made facetiously, social problems in our society are difficult to analyze. The development of a solution to any problem is not a simple procedure. It has become a cliche to say that social problems are always complex in structure. Whether you are concerned with juvenile delinquency, international relations in the nuclear age, divorce, crime, labor-management problems, highway safety—no one of these many-sided situations arises from a single cause or is amenable to a simple solution.

For example, I am not sure that I know what juvenile delinquency is. Apparently, it is a descriptive label characterizing the behavior of groups of young people—behavior inconsistent with the norms of the adults of the community—that creates anxiety and poses a threat. Obviously there are many causative factors in this particular problem. There may be disorganization within the family, severe personality disturbance on the part of individual young people, failure of the community to provide an adequate school program to meet the needs of certain students, lack of organized recreational activities, and so on. Whatever the causes may be, it is certain that simple solutions, such as enforcing a curfew rule, arresting ring-leaders and placing them on probation, or even attempting to provide specially trained youth workers are unlikely to get at the root of

the problem.

Unfortunately there is a tendency to shift responsibility for working out approaches to social problems to the specialist, to the scientist. I say unfortunately because even though the scientist may develop insights into the dynamics of the problem, the solution will come only through coordinated community action.

We are concerned with problems of alcohol and alcoholism. I might quote to you statistics on the reported relationship between drunkenness and alcoholism on the one hand and broken homes, welfare and hospital costs, crime and delinquency on the other. Annual consumer expenditures for alcoholic beverages exceed 10 billion dollars, a rather staggering figure. This contrasts with something like seven or eight billion for schools, while the amount contributed by citizens for the maintenance of churches is by comparison strikingly low.

More Alcohol Problems

We have reports of inefficiency in industry attributable to the after effects of drinking. We read of alcohol-involved traffic accidents and fatalities, arrests for driving under the influence, as well as for public drunkenness. These statistics are of tremendous magnitude. You will find them listed in a number of textbooks. Whether or not the statistics are valid is secondary to the fact that they have induced some people to define the problem in terms of the statistics and to formulate an attack on the surface conditions from which the statistics are derived. Frankly I feel that this is an over-simplification. The statistics need to be examined critically, but we have only begun to understand approaches in depth to alcohol problems after we have determined their validity.

As you know, during the early period of American life, alcohol use was generally accepted. In colonial times, beer and the fermented beverages, including a little wine, were used generally by everyone. By 1725 rum, which had become an article of major economic value, was also incorporated in the dietary patterns of society. But drunkenness was frowned upon. There were stringent penalties for public intoxication; there were penalties for giving spirits to indentured servants and to slaves.

A distinction was made between drinking and abuse of drinking—a distinction which is sometimes overlooked today. There was misinformation about action of alcohol in the body. It was assumed that alcohol behaved in somewhat the same way as the opiates—namely, that excessive amounts create tissue changes which call for greater amounts. But at the same time, alcohol was believed to have beneficial effects, was thought to have dietary values. It was also asserted that man had the capacity to control his appetite—not only the capacity but also the responsibility to control his appetite. The result was that alcohol use was acceptable within a framework of morality; abuse was not sanctioned because it exceeded the boundaries of moral conduct.

Public drunkenness became excessive, became a matter of concern, and there emerged the first steps in the direction of a temperance movement. I would point out to you that temperance in 1800 meant just that—it meant the controlled use of fermented beverages containing alcohol and specifically the elimination of the high alcohol content beverages—rum, gin, whiskey.

The decades 1800-1840 were a period in which a strong appeal for temperance was made to the dignity, the inherent decency of the individ-

ual, based on the concept of the perfectability of man. This appeal was channeled through the various lay and religious journals, though organizations of citizens, through the churches. But temperance was not essentially a religious program at this time. It was a social reform movement supported by many elements in the community.

This was a period of change in philosophy of government. It was a period when civic and economic influence was shifting from the Eastern seaboard to the Midwest. It was a period of ferment—a period of social ferment in which the ideal of self control with respect to alcohol use was advanced. Frankly, it was not accepted too generally—not essentially because of limitations in the ideal but because of wide changes that were occurring.

Shift in Tactics

By 1840 the tactics of temperance leaders shifted to the so-called "American" pledge which called for "total abstention from all beverages that might intoxicate." This policy was documented by the interpretation of certain theologians that the wines referred to in the Bible were unfermented. By 1850 we can observe a shift from an appeal to the inherent dignity of man based on the perfectability of the individual to a legalistic approach which insisted that society has a responsibility to protect against alcohol in all forms those who are weak, those who are unable to handle themselves in constructive fashion. Alcohol per se was defined as being inherently evil. Therefore, legislative control and, if possible, elimination of the manufacture and sale of alcoholic beverages should be sought.

The first state prohibition law, which remained in effect more or less down to Repeal in 1933, was passed in Maine in 1851. There ensued a wave of interest in prohibition legislation, particularly in New England, but also in other areas. Some states remained dry for a period of three or four years, then a shift of sentiment restored them to the wet column again. But from that period, rougly 1850-1920, there was a concerted drive aimed at eliminating the manufacture and sale of alcoholic beverages from our society on the national scene—a drive which succeeded a drive which I think will have to be analyzed as one of the outstanding attempts at social reform in the 20th century.

While this shift from a permissive and an inspirational level to the legalistic was taking place, other things were happening. There was the beginning of a great migration movement which saw Irish, Germans and Swedes coming to this country. The Germans and Swedes particularly moved into the open areas of the Middle West; the Irish settled mainly in the cities. These people brought with them different standards with respect to the use of alcoholic beverages, different standards of morality regarding that use, different church memberships and different cultural patterns. Further changes occurred in urban and rural life, church membership, and church activity. Other changes arose from World War I, as a result of expanded industrialization. Different patterns of family life, of housing, of transportation, of communication, and of the role of women emerged. Of particular concern to the school, some of the changes in family life reflect changes in adolescent roles.

In brief, some of the attitudes and concepts advanced today concerning the role of alcohol in our society have remained static over the last

century, notwithstanding the fact that our society has changed. It is my opinion that any attempt at understanding and prevention of alcohol problems and alcoholism must start with the social structure and the cultural attitudes of our people which relate to drinking, not of 75 years ago, but as they are today.

Drinking customs are learned within the culture. In our society today there are many different attitudes toward drinking. There is conflict about the objectives of alcohol education. There is legislation against drinking and driving in all parts of the country, but social practice and recreation involving automobile transportation have resulted in a large segment of our population, technically, becoming law-breakers, in that they attend social affairs, imbide varying amounts of an alcoholic beverage, and then drive home.

Major Barrier

The major barrier to definition and resolution of alcohol problems as they affect school and society resides in what might be characterized as our American drinking culture. We need to examine the role of drinking in our society, and having identified trends in the last generation or two, analyze and interpret their significance. We need to determine to what extent there is public understanding of the physical and psychological effects of alcohol in varying amounts, and the social implications of use and abuse. There is a need to evaluate the nature of alcoholism as a social problem. We have been concerned with the alcoholic as an individual sufferer. We must continue to be concerned but in a broader sense we need to understand alcoholism as a public health disorder, its causes, progression, and treatment, just as we seek to understand the public health problems of cardiovascular disorder, polio, cancer, mental retardation and mental illness.

What is the relationship between social drinking and alcoholism? Is alcoholism predominantly an expression of social deviation? Is alcoholism for some sufferers a symptom of a severe personality disorganization — and if so, how do we interpret this to the community so that understanding will be reflected in preventive and treatment measures?

These issues represent a framework within which we can approach the drinking culture of the community. But this must be done in a unified fashion rather than in the piecemeal approach which we have been following up to the present. The most productive results will be achieved when both the specific and the basic problems are explored simultaneously. Obviously this raises such questions as who has the responsibility in this exploration? The local community? The official agencies? The Committee on Alcoholism? The churches? The schools?

It has been estimated that there are approximately 70 million adult users of alcoholic beverages in the United States. The term "users" does not accurately describe the wide variations in patterns of use. Some people may have one or two drinks a year on a holiday or family festivity. Some may drink at intermittent occasions in connection with social affairs and entertainments. Still others may have one or two cocktails every night before dinner. Then there are the excessive drinkers, those individuals who find their recreation in taverns and in associations in which heavy alcohol consumption plays an important role. Some of these excessive drinkers may be alcoholics, but generally I

would distinguish them as a group from the approximate seven per cent of all users who have been labeled alcoholics or uncontrolled drinkers. Obviously, in talking about drinkers, drinking patterns, drinking excesses, and programs of alcohol education, it is important to keep in mind the particular targets at which we direct our educational materials.

Is there a relationship between rates of alcoholism and consumption rates among the several states? On inspection of the data, there would appear to be some correlation. For example, California, Massachusetts, and New York are high in consumption and also in rates of alcoholism. Some of the states low in consumption rates have low alcoholism rates. However, the relationship is not a simple one. California, Massachusetts, and New York have extensive urban industrialized areas. Their large populations are heterogeneous and reflect a number of different cultures. Per capita income is high. The states with low alcoholism rates are inclined to be rural, reflect a more homogeneous population, and have lower per capita incomes. Yet, among these differentials, the one that appears to be common is that of alcohol usage. This might be a convincing bit of evidence if one disregarded the fact that there are populations exhibiting a high consumption rate accompanying a low rate of alcoholism. I refer specifically to the Jews and to the Spanish, Italian and Greek nations. The Southern Mediterranean groups, in their rates of alcoholism, are strikingly low in contrast with the northern European countries, where the rates are high.

Certainly there is no alcoholism without alcohol. Yet, the evidence suggests that there are factors other than alcohol consumption that must be considered in attempting to arrive at a formulation of the nature of the disorder.

During the past century, with the rise and fall of conflicting attitudes and actions regarding alcohol use and abuse, the alcoholic and his problems have been submerged. Social action designed to correct the excesses associated with the use of alcoholic beverages has been chiefly legalistic, although where the uncontrolled drinker has been involved, punitive action has appeared appropriate.

The concept of alcoholism as a form of illness has been publicized widely during the past two decades. For many people this emerges as a strikingly new idea, one which they find difficult to reconcile with the more traditional symbol of "the drunkard" as a sinner or an irresponsible character. It is not surprising that the alcoholic himself does not understand his problem and that the community too has been unable to incorporate into the social conscience a perception of alcoholism which would produce constructive action.

But the definition of alcoholism as an illness is not basically a product of recent years. It was first mentioned in the professional literature at the turn of the 19th century. In 1804 a Scottish physician, Dr. Thomas Trotter, said:

"In medical language, I consider drunkenness, strictly speaking, to be a disease; produced by a remote cause, giving birth to actions and movements in a living body, that disorder the function of health . . . It is to be remembered that a bodily infirmity is not the only thing to be corrected. The habit of drunkenness is a disease of the mind." Trotter believed in the psychogenesis of the condition and in the need to suit treatment to the individual case. (To be continued, next issue.)

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ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

The psychology of alcoholism should concern itself more with the patient's normalities and assets for rehabilitation than with searching for the buds of abnormalities.

SOME THOUGHTS on the Psychology and the Psychiatry of Alcoholism

BY THOMAS J. HELDT, M.D.

IN any attempt at an evaluation of the subject matter under discussion, it is wise at the outset to define the position of the observer to the object to be observed.

To begin with, the alcoholic person is as much a person as any other person, regardless of affliction. The tuberculous patient is a patient in whose antibacterial defenses the tubercle bacillus has found a vulnerable spot. The alcoholic patient is one whose alimentation and metabolic processes have become subtly defenseless against recurrent intake of beverage alcohol, in disregard of the best intentions of the individual so affected. Hence let psychology and psychiatry pride themselves not too highly as to their answers to, and the surety of, their interpretations, solutions, and resolutions of the basic problems involved in the disease of alcoholism. Psychology and psychiatry here apply as they do in other medical problems and in essentially the same proportions. To the mind of this observer, the alcoholic patient demands as much, and usually not more, psychological attention and psychiatric care than does any other patient—however afflicted. There is at this time a tendency to overrate psychological processes and psychiatric techniques in behalf of the alcoholic patient. "Deep psychology" and ultra-special psychiatric methods apply no more to the alcoholic patient than to other patients—yet by all means as much. Then, too, the application of both, again, is at the level of ordinary "every day clinical psychology" and straightforward clinical eclectic psychiatry. The frank "distributive analysis" of Adolf Meyer applies more

Reprinted from *Michigan Alcoholism Review,* this article is another in the series prepared by members of the Michigan State Board of Alcoholism. Dr. Thomas J. Heldt is senior consultant, Division of Neurology and Psychiatry, Henry Ford Hospital, Detroit, Michigan.

TARGET: THE CLERGY

through Religion and Alcoholism Day

BY ASHTON BRISOLARA, M. ED.

THE unique and responsible role of the Clergy in the aesthetic, social, and moral development of our culture has long been recognized. As a representative of God on earth, armed with deep spiritual convictions and theological training, the priest, minister, and rabbi, are the endless object of "those in trouble."

In the confines of the vestry, the rectory, and the confessional, where confidentiality and zeal prevails, alleviation of human misery and the satisfying of human needs are sought with the anticipation of cordial reception and therapeutic results.

In a society as impregnated with drinking customs as ours, it would seem logical to assume that the problem of alcoholism would be a matter of daily concern to the clergy. And so it is.

When the clergy 'answered' the call to serve God, the world became his mission field, and all souls, regardless of race, color, guilt, or health, became his children. That God wished His special followers to seek out the depraved, the sick, the sinful, is evidenced from the Bible. And certainly the alcoholic, who was a person long before he was an alcoholic, falls within the confines of the ministry.

Reaching the clergy implies several objectives:

(1) *The prevention of alcoholism among the clergy by education; and treatment of alcoholic priests, ministers and rabbis.*

How many clergymen can recognize the danger signs of alcoholism? Realization of the dangers could promote prevention, elimination of "scandalous situations," the eradication of the ill founded stigma connected with alcoholism and other pathetic consequences associated with an alcoholic clergyman.

If religious superiors realized that an alcoholic is indeed ill, and that disciplinary action alone can scarcely be considered adequate therapy, they would approach the alcoholic clergyman in a truly more Christ-like and intelligent manner. How many gifted and talented "men of the cloth" spend their years making the circuit of every parish, every institution, and every superior within the confines of his religious district! Would that bishops, provincials of religious

orders, and other church superiors realized that geographic change alone has no medicinal value, that suspension, expulsion, transfer — some of which may eventually be necessary are for most purposes devoid of therapeutic value.

More important yet, would that those in authority could realize that an alcoholic clergyman is a sick person, but one who is treatable. How many more countless souls would be saved by these gifted "men of God" who are, like all human beings, afflicted with mortality and proneness to illnesses!

(2) *The ability of the clergy to attract those individuals troubled with alcoholism which, if left untreated, will eventually eradicate all religious and spiritual convictions.*

The individual differences among clergymen are as varied as in any other professional group. There certainly are, unfortunately so, some clergymen who by nature of temperament and capacity will never attract alcoholics, and perhaps, worse yet, any troubled soul. Their appearance, tone of voice, attitude, lack of "infinite" patience, deficiencies in relating to others, etc., preclude their acceptance by problem drinkers. Their avenues for good must be focused in other areas.

However, by far the majority of clergymen, because of their religious training, are able to communicate, so the problem of relating and attracting becomes synonymous with recognizing the needs of the troubled. It involves knowledge of accepting the alcoholic as a person, as a child of God, as a sick individual. Knowing how the alcoholic thinks, his mental blocks, his resentfulness, fears of non-acceptance, etc., are all necessary in order to draw him to seek advice and help from the church.

Knowing the tragic family involvements alcoholism causes and how to relate to the spouse and the children will enable the clergyman to assist those who must live with the problem, and who can play such an important role in motivating the individual afflicted with the problem. It is imperative to realize that there are wise and unwise approaches to the problem, there are needs, even spiritual ones, which must be supplied to the spouse and children of the alcoholic. In essence, it necessitates deep knowledge on the part of the clergy in order to approach alcoholism successfully.

How to handle problem drinking is not universally known by clergymen who have either considered alcoholism strictly as a moral or social problem, pinpointed in the term "sin," or as a subject shrouded by a cloud of taboo which has prevented its discussion from the pulpit. And even when this taboo was non-existent, how appallingly inadequate has the discussion of alcoholism from the pulpit been!

The demeanor, understanding tone, and sympathetic approach from the pulpit, in the confessional, and in the

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The Clergy Committee of the Committee on Alcoholism for Greater New Orleans holds a yearly crash program called Religion & Alcoholism Day.

Ashton Brisolara is executive director of the Committee on Alcoholism for Greater New Orleans. He is a graduate of Spring Hill College, Loyola University, the Columbia and Yale Schools of Alcohol Studies and is president of the Louisiana Institute of Alcohol Studies.

Reprinted by permission from the September, 1964 *Mind Over Matter,* a publication of the Tennessee Department of Mental Health.

AS I SEE ALCOHO

BY A MEMBER: W. A. B.

I am an alcoholic, but, by the grace of God, and the help of Alcoholics Anonymous, I have been sober for the past 24 hours and will be for the next 24 hours. I have not found it necessary to take a drink of anything that pertained to alcohol since February 15, 1954. I am a member of the Nashville Central Group of Alcoholics Anonymous, 107½ Union Street in Nashville.

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover.

The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership. We are self-supporting through our own contributions.

It is estimated that the membership is more than 350,000 in the United States, Canada, and some 80 other countries. There are now more than 10,000 groups throughout the world, including some in hospitals, prisons, and other institutions.

Alcoholics Anonymous' Twelve Steps are a group of principles, spiritual in their nature, which, if practiced as a way of life, can expel the obsession to drink and enable the sufferer to become happily and usefully whole.

The "Twelve Steps" are the core of the A.A. program of personal recovery from alcoholism. They are presented as suggestions only, based on the trial-and-error experience of early members of A.A. They describe the attitudes and activities that these early members believed were important in helping them to achieve sobriety. Acceptance of the Twelve

THE TWELVE STEPS

WE admitted we were powerless over alcohol—that our lives had become unmanageable.

CAME to believe that a Power greater than ourselves could restore us to sanity.

MADE a decision to turn our will and our lives over to the care of God as we understood Him.

MADE a searching and fearless moral inventory of ourselves.

ADMITTED to God, to ourselves, and to another human being the exact nature of our wrongs.

WERE entirely ready to have God remove all these defects of character.

HUMBLY asked Him to remove our shortcomings.

MADE a list of all persons we had harmed, and became willing to make amends to them all.

MADE direct amends to such people wherever possible, except when to do so would injure them or others.

CONTINUED to take personal inventory and when we were wrong promptly admitted it.

SOUGHT through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

HAVING had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

CS ANONYMOUS

Alcoholics can't wait for a scientific "cure" if they are to survive. Some have found a solution in A.A.

Steps is not mandatory in any sense.

Experience suggests, however, that members who make an earnest effort to follow these steps and to apply them in daily living seem to get far more out of A.A. than do those members who seem to regard the steps casually.

For it is only by accepting and solving our problems that we can begin to get right with ourselves and with the world about us—and with Him, who presides over us all. May all of us sense more deeply the inner meaning of A.A.'s simple prayer:

"God grant us the serenity to accept the things we cannot change,
Courage to change the things we can,
And wisdom to know the difference".

A.A.'s "Twelve Traditions" apply to the life of the fellowship itself. They outline the means by which A.A. maintains its unity and relates itself to the world about it, the way it lives and grows. The Twelve Traditions are suggested principles to insure the survival and growth of the thousands of groups that comprise the fellowship. They are based on the experience of the groups themselves during the crucial formative years of the movement.

There are two kinds of A.A. meetings, open and closed meetings. The open meeting is a group meeting that any member of the community, alcoholic or nonalcoholic, may attend. The only obligation incurred is that of not disclosing the names of A.A. members outside the meeting.

The closed meeting is limited to members of the local A.A. group, or visiting members of other groups. The purpose of the closed meeting is

THE TWELVE TRADITIONS

OUR common welfare should come first; personal recovery depends upon A.A. unity.

FOR our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

THE only requirement for A.A. membership is a desire to stop drinking.

EACH group should be autonomous except in matters affecting other groups or A.A. as a whole.

EACH group has but one primary purpose — to carry its message to the alcoholic who still suffers.

AN A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

EVERY A.A. group ought to be fully self-supporting, declining outside contributions.

ALCOHOLICS ANONYMOUS should remain forever nonprofessional, but our service centers may employ special workers.

A.A. as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.

ALCOHOLICS ANONYMOUS has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.

OUR public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.

ANONYMITY is the spiritual foundation of our traditions, ever reminding us to place principles before personalities.

To Use in Church and Community Work

Would you please put me on your mailing list? I am a rural church and community worker in the Pembroke area and have much contact with the families. When there are drinking problems I feel as though I should direct them to someone that might be able to help or direct an A.A. representative to them. Your publication will help me to understand the alcoholic better and show me where I best can serve.

Miss Joan Kiernan
Pembroke, N. C.

Request for Source Material

I am in the process of writing a paper for a graduate course at East Carolina College entitled "The Alcoholic and the Family" and would like to receive any source material that you may have on this subject.

Edward D. Thompson, Principal
Oriental School
Oriental, N. C.

Interested in Alcohol Education

Your magazine was recently introduced to me through the kindness of a friend. I was immediately impressed with its frankness and directness. I am interested in forming a group in Jones County to promote alcohol education and request that my name be placed on your mailing list as I feel that I will receive help from your publication.

Rev. Avery Lumsden
The Memorial Baptist Church
Maysville, N. C.

Indian Readers

I have just been reading a compilation of the *Inventory* issues. The clarity of thought and simplicity of expression is indeed very good and I would be very grateful if you will put our group on your mailing list.

The Al-Anon Family Group in Bombay will be looking forward to receiving regular issues of *Inventory* and we intend to compile the issues into volumes as they offer a wealth of information to many of our Al-Anon readers. Thank you.

Secretary, Al-Anon Family Group
Mazagon, Bombay 10
Maharashtra, India

Probation Officer Writes

I would like to receive your bimonthly publication of *Inventory*. I have read some of the back issues and enjoyed them very much. The articles are very informative and I find them useful in certain phases of my work.

Bob G. Beam
State Probation Officer
Marion, N. C.

Wants Alcoholism Literature

I am a student in the School of Public Health of the University of North Carolina. I was recently informed by the mental health clinic at Memorial Hospital of the availability of literature pertaining to alcoholism. I would appreciate it if you would place my name on the mailing list for *Inventory*.

Mrs. Burton Segall
Chapel Hill, N. C.

ALCOHOLISM—
THE COMMUNITY RESPONSIBILITY

BY VINCENT K. VANDRE
INFORMATION OFFICER
DIVISION OF ALCOHOLIC REHABILITATION
CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH

RESPONSIBILITY is a word loaded with meaning. It has a value to everyone, even those who deny its value. Responsibility brings thoughts of family, of the job, of the things we wish for our children. To most of us, responsibility means substance, reliability, reason.

The word *community* is much the same. Webster says a community is a body of people living in the same place under the same law. The definition implies responsibility, and we're back full circle to what we owe ourselves and others. Being part of a community implies a certain amount of responsibility. We obey the laws, we support our families, we show up at the job on time, and we take part to some extent in community activities.

But alcoholism is a word which screams defiance of responsibility and the community. It is an unfortunate word, because the first part, *alcohol,* is as full of emotion and conflict as our culture's fighting words —sex, religion, politics. The second part of this controversial word, *ism,* provides ammunition for those who automatically link the three letters with something undesirable and, therefore, *bad.*

When alcoholism and community responsibility are linked together, a cry goes up that—no matter how you define it, attack it, or justify it—

Until the whole community realizes its responsibility to treat the alcoholic like any other sick person, his number will not diminish.

Published by permission, this article has been condensed from an address delivered by the author during Alcoholism Information Week of 1963 at a meeting sponsored by the Alcoholism Council of the Monterey Peninsula, Monterey, Calif.

alcoholism is an *individual* problem, not a *community* responsibility. Alcoholics may have good reason for being the way they are, but "*I* drink and still manage to carry out *my* responsibilities to myself and those around me." This is the rationalization that goes on all the time; it is the reason that alcoholism still has a stigma attached to it; and it is the basis for most of the misunderstanding that exists about the sickness and those who suffer from it.

If *we* drink, we don't like the alcoholic because, figuratively, he gets away with murder. We don't like him because he gets away with the kind of behavior a *responsible* person cannot exhibit. How could we like an adult who continually acts like a child?

If *we* don't drink, the alcoholic is a living example of the evil which be-

tific riddle with no answer at this moment.

So while research continues into the possible physiological causes for alcoholism, equal attention must be given to the myriad of social and psychological factors which *may* play a part in its development.

The third and most compelling reason are the millions of alcoholics who are unwilling or unable to accept the basic tenets of A.A. and thus are cast into a treatment limbo.

If they can be helped by other means, those means should be found and employed. Alcoholism clinics and recovery houses are examples of other means. Psychiatric help in clinics and state hospitals often is needed by alcoholics with longstanding emotional problems. And physicians and clergy with training in the treatment of the emotionally ill often can help alcoholics.

Serving as a bridge between the alcoholic, A.A. and these other means of recovery is an even newer American social phenomenon than Alcoholics Anonymous. Groups of citizens who band together in a community alcoholism committee or council, such as you have on the Monterey Peninsula, are dedicated to the principle that alcoholics are *sick* people who can be *treated.* Although the sparkplugs behind such councils in the past often were recovered alcoholics or members of their families, today more and more nonalcoholic members of the community are participating in this type of voluntary activity. They believe it is a citizen's responsibility to help those who no longer can help themselves.

They also know that the dissemination of knowledge about alcoholism is their most important function. There are alcoholism *danger* signs related to how, when and why a person drinks. The sooner that a heavy drinker worried about his drinking seeks help, the sooner he can readjust the distorted focus of his thinking and return to sane living. The alcoholism council and information center can help this man or woman find assistance.

Local councils have a unique advantage over the medical profession, the clergy and even A.A.; they represent *all* of the community's interests, rather than those of a profession, an agency or a philosophy.

If we accept the alcoholism council as a group of volunteer citizens forming the structure of a bridge across which the alcoholic may walk to a source of recovery, where are the resources to which he can be referred?

Sources of Referral

There is A.A., of course, and Al-Anon, the family group of Alcoholics Anonymous, and Alateen, for youngsters with alcoholic parents or those who just need the counsel of people they know and trust. But only a fraction of this country's alcoholics and their families affiliate with A.A.

Usually, there are a small number of understanding and knowledgeable doctors in a community who will provide medical attention. But there are not enough.

Sometimes a local hospital will accept alcoholics without question. More often emergency care can be obtained only at the *county* hospital and even *that* is not always easy.

There are a number of community outpatient clinics for the emotionally disturbed in California. It is an unfortunate fact that—with notable exceptions—long waiting lists, antipathy of the staff toward alcoholics, and the frank admission of scant knowledge about the disease bar most people with drinking problems from their doors.

Humane, fair-minded judges and law enforcement officials work in most communities. But they feel helpless and react in frustration when the same faces appear week after week in the drunk court.

The clergy may have empathy, if not sympathy, for the alcoholic but few are professionally prepared to to deal with the drinker on an objective, unmoralistic basis.

There are recovery houses in some communities but still too few. This many sound like a negative assessment of the chances for an alcoholic to find recovery in the typical California community—and it is.

Until the whole community realizes its responsibility to treat the alcoholic like any other sick person, his number will not diminish. Until —and with all respect to A.A.—until the alcoholic is thought of as a deeply troubled person, often with physical disabilities, rather than as a separate breed, he will continue to exist outside of the main stream of society. For some, this is a fair exchange, but others will be unwilling to exchange a life of compulsive drinking for a life of compulsive nondrinking.

Until the medical profession fully accepts alcoholism as a complicated pathological entity, the alcoholic will receive less skilled attention than is his due.

Until the clergy, the social workers, the nurses and the other caretakers of the community learn more about alcoholism and learn to accept the alcoholic for what he is, the gaps in services available to him will continue to exist.

More important than a change for the better in all of these people and groups is the change necessary in the attitudes of the rest of us. If we continue to sanction laws which put the alcoholic in jail instead of a hospital or clinic, how can we blame the police and the judges for the "revolving door."

If we practice a mild kind of ostracism on the man who won't drink with us, how can we wonder at the spread of alcoholism among those who find in the bottle a temporary escape hatch from responsibility and conformity?

If we tell the alcoholic he is a bum and a no-good, how do we expect him to be better?

If we glorify drinking as a status symbol, as a stimulating pastime, instead of a flirtation with unconsciousness, how do we expect our children to be aware of alcohol's social and physical implications?

If we, as a community, do not accept the alcoholic as readily as the diabetic, the stroke victim, or the retarded child, why do we expect the alcoholic to come forward and be treated? And if we do accept him, and he comes forward with the trust born of desperation, will we see that he gets the treatment and rehabilitation he needs?

The answer to these questions can be found only in *your* own community.

Another flaw is also shared by a number of progressive communities in California. The flaw is the apparent lack of coordination between voluntary agencies concerned with alcoholism, official agencies charged with prevention and control of chronic diseases, the various religious organizations which shelter and work with alcoholic men, and the philosophical or independent groups, such as Alcoholics Anonymous and alcoholic recovery houses.

In large cities—Los Angeles, San Francisco and Sacramento, for example—this lack of coordination and the failure to integrate services available to the alcoholic are painfully

evident.

The alcoholic in these cities—and many of the smaller communities as well—often goes on a shopping expedition. He starts with a physician, who may limit his attention to a physical examination and an admonition to stop drinking.

A strange pastor or minister—not the alcoholic's own clergyman if he has one—is the next stop. He probably receives courteous attention but little understanding, and the weary walk goes on.

Obviously, a shopping expedition may go on for weeks or months, with benders, arrests, even hospitalization in a state institution making the alcoholic's path ever more erratic.

Finally, if he is lucky enough to live on the Peninsula, he may hear of the Alcoholism Information Center, located on the grounds of the Monterey Peninsula Convalescent Hosiptal in Carmel where someone will talk with him—or perhaps a family member—and decide where he should be referred for help. It may be Beacon House, A.A., Al-Anon, a local doctor, the county hospital, the welfare or health department, depending on the need.

Then what happens? If Monterey, Carmel, Seaside, Salinas and Watsonville are like small cities in other highly populous areas, the alcoholic begins to get lost in the maze.

He may attend an A.A. meeting, all right, and develop the shakes while he's there. Recovered alcoholics know this painful experience from past personal history and will try to get medical help. If someone at the meeting knows an attendant in the emergency room at the county hospital in Salinas, maybe the alcoholic will get a bed and attention for a few hours. Otherwise, he shakes it out cold turkey, as the saying goes.

The next day the alcoholic shows up at Beacon House and is accepted because a room is available and he is obviously sincere in his desire to stop drinking and to resolve some of the problems which he has been unable to face.

For at least two weeks, the alcoholic will live with other convalescing guests and will not be forced to look for a job. Beacon House will extend credit until the director and his assistant believe the man—or woman, since this is one of the few co-educational recovery establishments in California—is ready to seek employment. He may remain for a longer period after finding work because Beacon House encourages stability—emotional as well as economic—before a guest leaves.

Obtaining employment may be difficult, even though good relationships exist between the local employment office, Beacon House and the alcoholism council. Jobs are scarce in a community with a large military establishment nearby and the alcoholic may have skills which are surplus in Monterey. Dishwashing, yard cleaning and work as a hospital attendant may be menial, in the eyes of some, for alcoholics with training as attorneys, accountants, machine operators and newspapermen, but a job is a job. An alcoholic often is happy to find any kind of work because it has been so long since anyone trusted him to do something more responsible than open a bottle.

Assuming that a paycheck, however small, is coming in each week and that the alcoholic is doing well in the Beacon House environment, now what? He has stopped drinking; he is attending A.A. meetings regularly; and physically, he is in the best shape in years.

But two things are nagging at him. A family is somewhere in the East and he wants to get in touch with

them. The emotional problems which accompanied his drinking and often plunged him into deep depressions are still with him, and now there is no bottle to hide in.

He wants to make an appointment at the county mental health clinic but finds: (1) he is not a county resident and therefore ineligible for assistance; (2) the waiting list is three months; and (3) in any case, he could not take time off from work during regular clinic hours.

Social work counseling at the county welfare department is out because he does not qualify for indigent aid and he cannot get help with his family problem because they are in another state.

He is dry and no longer a jail guest, so even the probation officer is unable to help. This kind of situation—extreme and hypothetical as it may be—can provide the setting for an alcoholic relapse and a long walk down the familiar, dreary road.

There is no pat answer to the problem of coordinating an alcoholic rehabilitation program. Principally, it is lack of communication and lack of knowledge which hamstrings development of a truly comprehensive alcoholism service.

The machinery and the agencies are already in the community. What is needed is the interest, influence and goodwill of citizens like yourselves who are willing to turn out on a cold night of Alcoholism Information Week to learn more about one of this country's greatest social dilemmas.

If you are willing to spend two hours on a week night to discuss alcoholism, you may be ready to get down to brass tacks with county and city governments. You may be ready to assume community responsibility for the alcoholic.

Are you?

THE PSYCHOLOGY AND PSYCHIATRY OF ALCOHOLISM

CONTINUED FROM PAGE 11

study, his counseling, and his treatment of the alcoholic patient.

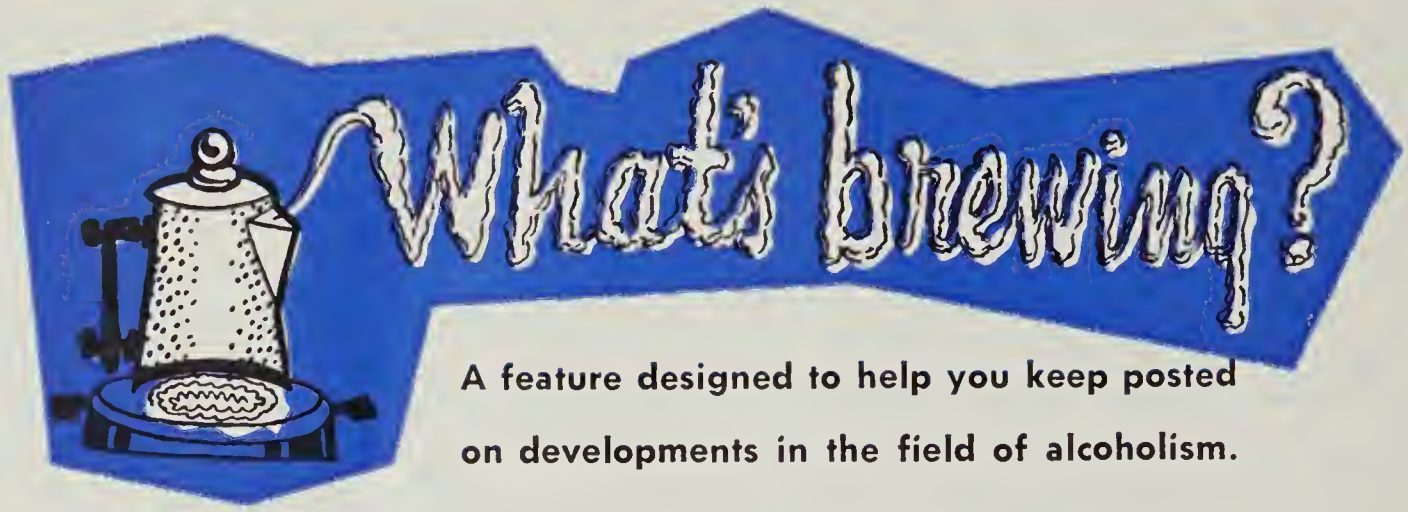
Attitudes toward a public problem, be it disease or the misbehavior of an individual citizen, find more formulation in tradition than in scientific interpretation and probable proof. Wide audience is given to the Portugese tradition that the juice of the grape has gained its effect upon man because of the manner of its growth, to wit: The original grower of grapes is credited with first fertilizing and irrigating his vineyard liberally with the blood of the turkey, then with the blood of the lion, and lastly with the blood of the monkey. Hence, man in ingesting wine, and beverage alcohol generally, will according to the quantity consumed, first conduct himself with pride and strut, then with the pugnaciousness of the lion, and finally with the nonsensical gibberish of the monkey. (To most laymen such legend carries as much weight as the latest scientific findings of Roger J. Williams.)

The psychology of alcoholism must include adequate consideration for kindred studies and especially those of sociology, ethnology, genetics, ecology, and even anthropology.

Psychiatry in alcoholism stands in position of consultation and can offer reliable assistance when abnormalities are added to the daily reactions of the alcoholic patient.

In summary, it may be said that the psychology of alcoholism should concern itself more with the normalities of the alcoholic patient and his assets for rehabilitation than with searching for the buds of abnormalities.

The psychiatrist, too, will be wise "not to jump to conclusions."



WASHINGTON, D. C.: The long established practice of jailing alcoholics for a few days, or at the most a few months, then turning them loose with no attempt to rehabilitate them has been challenged through a recent court action instituted by the Washington, D. C. Area Council on Alcoholism and the National Capital Chapter of the American Civil Liberties Union. The Council and the ACLU will appeal a public drunkenness conviction to a higher court. The case is intended to test the "right" of an alcoholic to receive treatment instead of going to jail. The hope is that the court will rule that it is unconstitutional to jail victims of a "disease" over which they have no control. If the court should rule that alcoholism is an illness not a crime, the decision would make it unconstitutional to jail so-called "revolving door" drunks. As far as can be determined, no test of the constitutionality of jailing alcoholics has previously been made. The present test was probably inspired by a recent decision by the United States Supreme Court, in a case involving a narcotics addict, which held that jailing a person for having an illness is "cruel and unusual punishment" and is, therefore, in violation of the Eighth Amendment to the Constitution.

NATIONAL COUNCIL ON ALCOHOLISM: The National Council on Alcoholism has announced the establishment of a Memorial Fund in honor of the late E. M. Jellinek, author of "The Disease Concept of Alcoholism," who died October 22, 1964. According to Mrs. Marty Mann, executive director of the NCA, the Memorial Fund will be used to make cash awards to persons or institutions making exceptional contributions in the field of alcoholism. Exact details of the method of awarding the funds will be announced later.

NEW BRUNSWICK, NEW JERSEY: Dr. Milton Maxwell will assume the duties of professor of sociology in the Rutgers Center of Alcohol Studies and executive director of the Rutgers Summer School of Alcohol Studies in July of 1965. He succeeds Raymond G. McCarthy, who died last June. Dr. Maxwell has been on the faculty of Washington State University at Pullman, Wash., since 1945 and has taught or done research at the University of Washington and the Universities of Texas, Utah, North Dakota, South Carolina, Yale and Rutgers. Dr. Maxwell will continue his research on alcoholism in industry and on Alcoholics Anonymous in addition to being responsible for planning and administering the operations of the Summer School of Alcohol Studies. He is co-author of the text, "Introductory Sociology," now in its sixth edition with J. B. Lippincott Co. Among his many articles which have appeared in various professional journals are "Drinking Behavior in the State of Washington" and "Early Identification of Problem Drinkers in Industry." Dr. Maxwell is a fellow of the American Sociological Association, the Society for the Study of Social Problems and the American Association of University Professors.

NEW BRUNSWICK, NEW JERSEY: Adults who worry about teen-agers' drinking habits should first take a long look at their own. The idea that "young people do not invent the idea that they should drink (or abstain); they learn it," is central to a new book, "Drinking Among Teen-agers," issued this month by the Rutgers Center of Alcohol Studies. Written by Dr. George L. Maddox of Duke University and Dr. Bevode C. McCall of Wayne State University, the volume is based on a depth study of the drinking patterns of 1,962 teen-agers in a middle-sized Michigan community. In its introduction, written by Mark Keller, the book is described as "the most important work of the present generation on the subject of youth drinking." Keller is editor of the monograph series of the Rutgers Center of Alcohol Studies in which the book is included.

TULSA, OKLAHOMA: The annual meeting and institutes of the National Council on Alcoholism will be held in Tulsa, Oklahoma April 7, 8 and 9, 1965 at the Hotel Mayo.

CHAPEL HILL, N. C.: Three staff members of the Education Division and a representative of a local alcoholism program attended a week-long seminar on "The Skillful Use of Mental Health Materials" conducted by the Mental Health Materials Center, Inc. of New York at the University of North Carolina January 17-22. They were, respectively, Mrs. Jackie Ransdell, Mrs. Lillian Pike and George Adams and Marshall C. Abee of Winston-Salem. Other participants were present from South Carolina, Georgia, New York, Florida, Maine and Canada. Below are some of the seminar faculty who shared their ideas and experience with the participants:

From left to right (standing) are: Alex Sareyan, executive director, Mental Health Materials Center, Inc.; Mrs. Lura Jackson, chief of public information, National Institute of Mental Health; Jack Neher, executive assistant, Mental Health Materials Center, Inc.; Miss Frances Jordan, family relations specialist, Agricultural Extension Service, North Carolina State of the University of North Carolina at Raleigh; and (seated) Mrs. Nina Ridenour, Ph.D., educational consultant, Mental Health Materials Center, Inc.; and Loyd Rowland, Ph.D., director of education and research, Louisiana Association for Mental Health.

CONTINUED FROM PAGE 19

side the hospital without the close supervision of the physician, it has been our repeated experience that this is the first step to another drunk, or the first step toward enslavement to a new addiction or habit.

Since I have described A.A. as a spiritual society, I should tell you what that means to me.

When I came to A.A. after everything else I tried had failed, I was a sick, confused, and above all, lonely soul. I think it must be very difficult for the nonalcoholic to understand the utter loneliness of the alcoholic or the depths of hopelessness to which society reduces us.

We experience repeated rejection by employers, friends and family, or we live under constant threat or fear of such rejection.

We come to believe that mankind itself has rejected us and there is no place where we can find acceptance as human beings.

Then, we come into A.A. and for the first time in years, we feel that we are among friends who understand and who are willing, even eager to share their experience, strength and hope with us. We become participating witnesses to the truth of those great paradoxes that distinguish this society of the redeemed, namely, that we can keep what we find in A.A. only by giving it away to others! Here's how it seemed to work in my case:

I had had a great deal of experience with drinking—but none in staying sober. My new A.A. friends gave me the wisdom of their experience, and in so doing, they seemed to widen the horizons of their own knowledge. They grew stronger, giving me the strength I lacked. I had very little hope, even of A.A., but I found hope in the good example which these sober alcoholics set for me—and as they saw me stop drinking and stay sober, the hope that they had given me was born anew within themselves. So, it was the A.A. group that sustained me during those first shaky weeks and months while I tried to do the things suggested in our Twelve Steps.

And, all this time, the A.A. group was giving me something else—something that for want of a better word, I shall call Love. This is not the kind of love that has anything to do with sex. There is no word in the English language that precisely defines this emotion, but there is a Greek word—*agape*—meaning a kind of outpouring, a spontaneous process of giving for its own sake, without expectation of praise or reward or anything back from the person on whom there is love bestowed.

It is, I believe, a divinely inspired quality which is passed on to us in A.A. by older members and which, like everything else that is good in our Fellowship, we can keep only as we give it away to others. It is a kind of love that can find fulfillment only by expressing itself. It is as though the old compulsions and obsessions to drink are replaced by a new compulsion to "care about" other alcoholics in this very special way.

Here lay the truth in the assurance of older A.A. members that it was I, the newcomer, who was conferring the favor by permitting them to take time from their business or recreation to bring me the A.A. message.

Here rests the wisdom in one of the stock phrases of our Fellowship —that we are not required to live like every other A.A. member, but God help us if we ever stop loving any one of them.

I think that I began to share in this love for other members of my

group at the same time that I—who had entered A.A. as an agnostic—began to acquire some faith in a Higher Power whose exact nature I could only vaguely comprehend but of whom I had heard other alcoholics testifying as the source of their sobriety. I saw repeated examples of the capacity of this Power to alter the lives of men and women— miraculously—and always for the better. And as my own personal experience justified my earlier faith, I began to acquire some knowledge of God and some glimmering of His will for me—a miracle in itself for me.

A.A. is not a religious program. We are not allied in any way with any of the branches of organized religion. We have no formal conception or theological description of the Diety in six of our Twelve Steps, but always in terms of "Higher Power," or "God as we understand Him."

A.A. is not a religious program, but it is a spiritual program based on the assumption that our alcoholic problems can be solved only through the intervention of some Power greater than ourselves.

It is significant to me that wherever you go, you will find men and women of every creed, and no creed at all, reciting the Lord's prayer in unison at the conclusion of every A.A. meeting. Individual conceptions of the Father may vary, but the recognition of His Fatherhood and our utter dependence on Him are almost universal in our Fellowship.

And I think that A.A. is a spiritual program because of the love that is its motivating force. The active alcoholic devotes an inordinate proportion of his time to drinking—to acts of drinking, to devising the means of getting a drink, the attempting to justify or cover up his drinking, to efforts to avoid its consequences. When these things are removed from the life of the alcoholic who becomes sober, it leaves a great void—and that void must be filled.

I think that it is the repeated acts and manifestations of love in A.A., the things we do because we care about other alcoholics, that fill this void, and that this is one of the secrets of such success as we have had.

It is because we care so much about other alcoholics, because our faith in A.A. is so great and because our desire to bring others the good news of our recovery is so compelling that we have sometimes claimed more for A.A. than should be claimed and have made foolish and uncharitable remarks about others working in this field. I make this statement in explanation, rather than in justification of our shortcomings.

We have not always fully appreciated the good work which others are doing in behalf of alcoholics. When the official and private alcoholism programs began to come into existence, many A.A. members regarded them with suspicion and were fearful and apprehensive about what effect their operations might have on A.A. and on the alcoholic generally. Experience has since taught us that these fears and apprehensions were baseless. The agencies have multiplied and prospered, but so has A.A.

Now we are in the dawning of a new era, when A.A.'s who have had the opportunity to know the official and the private alcoholism agencies and the work they are doing for alcoholics seek their friendship and understanding. We need their help. We respect their achievements. We have a sincere desire to cooperate with them to the fullest within the framework of our Twelve Traditions.

We may not always see eye to eye, but we all share a common objective —the recovery and rehabilitation of the sick alcoholic.

DIRECTORY OF OUTPATIENT FACILITIES
for
ALCOHOLICS AND/OR THEIR FAMILIES

Competent Help Is Available At The Local Level

Key to Facility and its Service

***Local Alcoholism Programs**

for
(Alcoholics and Their Families)

—Education
—Information
—Referral

†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: ALpine 3-7567.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m.-4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon.-Fri., 9:00 a.m.-4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Dr. D. D. Carroll, Director; 102 Laurel Hill Rd.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00-5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m.-12:00 noon. Thurs., 2:00-4:00 p.m.

**Wayne Council on Alcoholism;* A. T. Griffin, Jr., Executive Director; P. O. Box 1320; Phone: 734-0541.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Director; P. O. Box 2371; 915 Dickinson Ave.; Phone: 758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

*†*Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone: TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Educational Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

†*Mental Health Center of Wilmington and New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 763-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; **Hours:** Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

*†*Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. A. T. Ayscue, Director; Box 100; Phone: 257-4538.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

Library Books—Books on alcoholism are available from the North Carolina State Library through local libraries to residents of North Carolina. To obtain any of the books listed in the March-April, 1964 issue of **Inventory,** go to your community library and make the request.

Staff Speakers—members of the Raleigh and A.R.C. staffs are available for speeches before civic and professional groups.

Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

Consultant Service—for establishment of local programs.

These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

Education Division, N. C. Department of Mental Health
P. O. Box 9494
Raleigh, N. C.

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